CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospital and Provider Operations

(Amendment)

907 KAR 3:005. Physicians' services.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 42 C.F.R. 440.50, 415.152, 415.174, 415.184[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to physicians' services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy.

Section 1. Definitions.

(1) "Common practice" means a contractual partnership in which a physician assistant administers health care services under the employment and supervision of a

physician.

(2) "CPT code" means a code used for reporting procedures and services performed by physicians and published annually by the American Medical Association in Current Procedural Terminology.

(3) "Department" means the Department for Medicaid Services or its designated agent.

(4) "Direct physician contact" means that the physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(5) "Emergency care" means:

(a) Covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or

(b) Emergency ambulance transport.

(6) "EPSDT" means early and periodic screening, diagnosis, and treatment.

(7) "Global" means the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(8) "Graduate medical education program" or "GME" means one (1) of the following:

(a) A residency program approved by:

1. The Accreditation Council for Graduate Medical Education of the American Medical Association;

2. The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

3. The Commission on Dental Accreditation of the American Dental Association; or

4. The Council on Podiatric Medicine Education of the American Podiatric Medical Association; or

(b) An approved medical residency program as defined in 42 C.F.R. 413.75(b) [~~42 C.F.R. 413.86(b)~~].

(9) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires few additional physician resources; or

(b) Is clinically integral to the performance of the primary procedure.

(10) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(11) "KenPAC" means the Kentucky Patient Access and Care System.

(12) "KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.

(13) "Locum tenens" means a substitute physician:

(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and

(b) Whose services are paid under the participating physician’s provider number.

(14) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(15) "Medical resident" means one (1) of the following:

(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or

(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:

1. An individual with a:

a. Temporary license;

b. Resident training license; or

c. Restricted license; or

2. An unlicensed graduate of a foreign medical school.

(16) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically-impossible or improbable use of CPT codes; or

(d) Are described in current procedural terminology as inappropriate coding of procedure combinations.

(17) "Other licensed medical professional" means a health care provider other than a physician, physician assistant, advanced registered nurse practitioner, certified registered nurse anesthetist, nurse midwife, or registered nurse who has been approved to practice a medical specialty by the appropriate licensure board.

(18) "Physician assistant" is defined in KRS 311.840(3).

(19) "Screening" means the evaluation of a recipient by a physician to determine the presence of a disease or medical condition and if further evaluation, diagnostic testing or treatment is needed.

(20) "Supervising physician" means a licensed physician who directly oversees a

physician assistant or other licensed medical professional.

(21) "Supervision" is defined in KRS 311.840(6).

(22) "Timely filing" means receipt of a claim to Medicaid:

(a) Within twelve (12) months of the date a service is provided;

(b) Within twelve (12) months of the date retroactive eligibility is established; or

(c) Within six (6) months of the Medicare adjudication date, if the service is billed to Medicare.

(23) "Unlisted procedure or service" means a procedure for which there is not a specific CPT code and which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation.

(1) A participating physician shall be licensed as a physician in the state in which the medical practice is located.

(2) A participating physician shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeals process, and sanctions; and

(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation.

(3) A participating physician shall comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d and 45 C.F.R. Parts 160 and 164.

(4) A participating physician shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of that decision prior to the delivery of service. If the provider accepts the recipient, the provider:

(a) Shall bill Medicaid rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid as specified in Section 4 of this administrative regulation if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the basis of:

1. The service being incidental, integral, mutually exclusive, or global to a covered service;

2. Incorrect billing procedures;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

Section 3. Covered Services.

(1) To be covered by the department a service shall:

(a) Be medically necessary;

(b) Effective August 1, 2006, clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) [~~A covered service shall be a medically-necessary service which is:~~

~~(a)~~] Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) [~~(b)~~] Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

(b) A service provided by a locum tenens physician who provides direct physician contact;

(c) A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(d) The telephone analysis of emergency medical systems or cardiac pacemaker if provided under physician direction;

(e) A preauthorized sleep disorder service if provided in a physician operated and supervised sleep disorder diagnostic center;

(f) A telehealth consultation provided by a consulting medical specialist in accordance with 907 KAR 3:170; or

(g) A service provided by a physician assistant in accordance with Section 6 of this administrative regulation.

(3) A service provided by an individual who meets the definition of other licensed medical professional shall be covered if:

(a) The individual is employed by the supervising physician;

(b) The individual is licensed in the state of practice; and

(c) The supervising physician has direct physician contact with the recipient.

Section 4. Service Limitations.

(1) A covered service provided to a recipient placed in "lock-in" status in accordance with 907 KAR 1:677 shall be limited to a service provided by the lock-in provider unless:

(a) The service represents emergency care; or

(b) The recipient has been referred by the "lock-in" provider.

(2) An EPSDT screening service shall be covered in accordance with 907 KAR 1:034, Sections 3 through 5.

(3) A laboratory procedure performed in a physician’s office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.

(4) Except for the following, a drug administered in the physician’s office shall not be covered as a separate reimbursable service through the physician program:

(a) Rho (D) immune globulin injection;

(b) An injectable antineoplastic drug;

(c) Medroxyprogesterone acetate for contraceptive use, 150mg;

(d) Penicillin G benzathine injection;

(e) Ceftriaxone sodium injection;

(f) Intravenous immune globulin injection;

(g) Sodium hyaluronate or hylan G-F for intra-articular injection;

(h) An intrauterine contraceptive device; or

(i) An implantable contraceptive device.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F, shall

be covered within the scope and limitations of these federal regulations.

(6) Coverage for a service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible psychiatrist shall be limited to four (4) services, per physician, per recipient, per twelve (12) months.

(7) Coverage for an evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service.

(8) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(9)(a) An anesthesia service shall be covered if administered by an anesthesiologist who remains in attendance throughout the procedure.

(b) Except for an anesthesia service provided by an oral surgeon, an anesthesia service, including conscious sedation, provided by a physician performing the surgery shall not be covered.

(10) The following services shall not be covered:

(a) An acupuncture service;

(b) Allergy immunotherapy for a recipient age twenty-one (21) years or older;

(c) An autopsy;

(d) A cast or splint application in excess of the limits established in 907 KAR 3:010, Section 4(5) and (6);

(e) Except for therapeutic bandage lenses, contact lenses;

(f) A hysterectomy performed for the purpose of sterilization;

(g) Lasik surgery;

(h) Paternity testing;

(i) A procedure performed for cosmetic purposes only;

(j) A procedure performed to promote or improve fertility;

(k) Radial keratotomy;

(l) A thermogram;

(m) An experimental service which is not in accordance with current standards of medical practice; or

(n) A service which does not meet the requirements established in Section 3(1) [~~has been determined not medically necessary by the department~~].

Section 5. Prior Authorization Requirements and KenPAC Referral Requirements.

(1) The following procedures shall require prior authorization by the department prior to reimbursement:

(a) Outpatient surgery (performed in an outpatient hospital setting);

(b) Cardiac catheterization;

(c) Lithotripsy;

(d) Computed tomography (CT) imaging;

(e) Computed tomographic angiography (CTA);

(f) Computed tomography guidance;

(g) Magnetic resonance imaging (MRI);

(h) Magnetic resonance angiogram (MRA);

(i) Magnetic resonance spectroscopy;

(j) Positron emission tomography (PET);

(k) Dual energy X-ray absorptiometry (DXA);

(l) Radiographic absorptiometry;

(m) Cineradiography/videoradiography;

(n) Xeroradiography;

(o) Ultrasound subsequent to second (2nd) obstretic ultrasound;

(p) Unlisted procedure;

(q) Myocardial imaging;

(r) Cardiac blood pool imaging;

(s) Single Photon Emission Computed Tomography (SPECT);

(t) Sensory nerve conduction test (SNCT);

(u) Magnetic resonance cholangiopancreatography (MRCP);

(v) Topographic brain mapping;

(w) Magnetic source imaging;

(x) Fluorine-eighteen (18) fluorodeoxyglucose (F-eighteen (18) FDG) imaging;

(y) Electron beam computed tomography (also known as Ultrafast CT, Cine CT); and

(z) Magnetic Resonance Technology (MRT)-General.

(aa) [~~(a) Allergy immunotherapy for a recipient under the age of twenty-one (21) years;~~

~~(b)~~] Gastric restrictive surgery or gastric bypass surgery;

[~~(c) A positron emission tomography (PET) scan;~~]

(bb) [~~(d)~~] A procedure that is commonly performed for cosmetic purposes;

[~~(e) A sleep disorder service;~~]

(cc) [~~(f)~~] A surgical procedure that requires completion of a federal consent form; or

(dd) [~~(g)~~] An unlisted procedure or service.

(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.

(b) Eligibility verification shall be the responsibility of the provider.

(3) A physician shall request prior authorization by mailing or faxing:

(a) A written request to the department with sufficient information to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and

(b) [~~support medical necessity and,~~] If applicable, any required federal consent forms.

(4) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.

Section 6. Physician Assistant Services.

(1) With the exception of a service limitation specified in subsections (2) and (3) of this section, a [~~medically necessary~~] service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:

(a) The service meets the requirements established in Section 3(1) of this administrative regulation;

(b) [~~(a)~~] The service is provided through direct patient interaction;

(c) [~~(b)~~] The service is within the legal scope of certification of the physician assistant as specified in 201 KAR 9:175;

(d) [~~(c)~~] The service is billed under the physician's individual provider number with the physician assistant's number included; and

(e) [~~(d)~~] The physician assistant complies with:

1. KRS 311.858; and

2. Sections 2(2) and (3) of this administrative regulation regarding physicians' services.

(2) A [~~The~~] same service performed by a physician assistant and a physician on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:

(a) A physician noncovered service specified in Section 4(10) of this administrative regulation;

(b) An anesthesia service;

(c) An obstetrical delivery service; or

(d) A service provided in assistance of surgery.

Section 7. Appeal Rights.

(1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

907 KAR 3:005

REVIEWED:

Date	J. Thomas Badgett, MD, PhD, Acting Commissioner Department for Medicaid Services
Date	Mike Burnside, Undersecretary Administrative and Fiscal Affairs

APPROVED:

Date	Mark D. Birdwhistell, Secretary Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on August 21, 2006 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by August 14, 2006, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2006. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: 502-564-7905, Fax: 502-564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:005
Cabinet for Health Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the participation requirements for physicians and the coverage criteria for services provided by physicians to Medicaid recipients.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws requiring provision of medical services to Kentucky's indigent citizenry.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation fulfills requirements implemented in KRS 194A.050(1) related to the execution of policies to establish and direct health programs mandated by federal law.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides the necessary criteria and denotes the limitations for the provision of medically necessary physician services to Medicaid recipients.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment establishes the utilization of criteria by the department to determine the clinical appropriateness of any given service.
(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure appropriateness of care and to maintain the viability of the Medicaid program.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by establishing the use of criteria to determine the clinical appropriateness of care.
(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation assists in the effective administration of the statutes by establishing the use of criteria to determine the clinical appropriateness of care.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All fee for service Medicaid recipients and all physicians enrolled in the Kentucky Medicaid program (approximately 15,000).

(4) Provide an assessment of how the above group or groups will be impacted by

either the implementation of this administrative regulation, if new, or by the change if it is an amendment: Criteria will be established for providers regarding the clinical appropriateness of care.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: The Department for Medicaid Services (DMS) is amending this administrative regulation in conjunction with the physician reimbursement administrative regulation, and estimates that the sum impact of all amendments will result in a budget neutral impact or savings depending upon utilization variables.
(b) On a continuing basis: DMS is amending this administrative regulation in conjunction with the physician reimbursement administrative regulation, and estimates that the sum impact of all amendments will result in a budget neutral impact or savings depending upon utilization variables.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.